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**BULLETIN**

OF THE

**SOUTH INDIAN MEDICAL ASSOCIATION.**

DECEMBER 1933.

## SIR FRANK CONNOR, D.S.O.,

*Surgeon-General with the Government af Madras.*

We welcome to our midst Sir Frank Connor, I.M.S., the Surgeon-General with the Government of Madras. This province has been specially fortunate in that we have been having as successive Surgeon-Generals officers, who apart from being outstanding in their professional career, have made their mark in the educational and administrative spheres. We trust that during his stewardship the same cordial relations between the Independent Medical Profession and the Chief Medical Adviser to the Government will continue and, further, that by the time he leaves his office he will be able to weld the various medical groups of South India into one unified profession co-operating with one another in their zeal and enthusiasm to serve the Public.

## Civil Hospitals and Dispensaries.

The Annual Report on the working of the civil hospitals and dispensaries in the Madras Presidency for the year 1932 is a mass of figures and tables with a severely formal introduction by the Surgeon-General. From beginning to end we do not come across a single sentence which reveals enthusiasm or could excite any hope. The report has obviously been written under a cloud of financial distress. Patients who seek treatment in the various institutions of all categories have greatly increased in numbers. The large addition to the population of the province and the deepening economic difficulties would chiefly account for this. The increasing number of patients in the State hospitals used to be pointed to as an indication of the growing popularity of the methods of modern medicine with the people of Madras. But the demand for medical relief is so great and the facilities for it so few that people crowd round any available centre irrespective of the methods of healing adopted therein.

In the last Triennial Report on the working of the civil hospitals and dispensaries in the Presidency the then Surgeon-General pointed out that this ever increasing demand on public institutions was creating a problem for the Government. We are not aware if the Government has bestowed any thought on it. During the year 1932 the number attending the out-patient departments of the various hospitals has increased by over 700,000 and the in-patients by over 5,000. Yet, as a result of retrenchment less money has been spent on medical relief. But we are very pleased to find that the death-rate for the year has been lower than in the previous five years. Evidently less revenue makes for greater efficiency !

There is one feature of the policy of the Government which must be seriously noticed. The opening of the *Rural Dispensaries* in this presidency has been a great boon to the sick public in the scattered villages and very small towns. Within a decade of the inception of the scheme some hurdreds of these rural medical centres have been working usefully. We regret therefore that the continuous progress of this scheme should have been hindered by financial considerations. We consider that ambitious building schemes and creation of new appointments carrying high salaries could very well wait, thus allowing a larger number of rural medical centres to be opened. While it is a mistake to stop, even temporarily, the expansion of this scheme we cannot sufficiently condemn the practice which is now and then followed, of converting subsidized rural dispensaries into "regular" dispensaries. Some dispensaries which have been doing useful work have thus been converted. Such conversion is directly against the aim of this scheme which is to encourage practitioners to settle down in rural areas and carry on medical relief without excessively taxing the Government or the local boards. When such centres are successful and popular, they should not be converted into ordinary departmental dispensaries but should be encouraged by opening similar centres elsewhere. There are various schemes waiting for funds, like the extension of leprosy, venereal and maternity clinics. Money that is frittered away on red-tape dispensaries could more usefully be spent on such special clinics.

We are glad to note that more is now being done for those suffering from leprosy than hitherto. And we are sure that the greater facilities that are now offered by the Government for the efficient treatment of its subordinates, would go a fair way to educate the public to treat the unfortunate sufferers from leprosy with greater sympathy and understanding.

# MEDICAL EDUCATION.

*Interim Report of the Committee of the British Medical Association.*

In appointing the Committee, the Council requested that at least an interim report should be presented at its June meeting. With this in view the Committee has restricted its attention to the main points of criticism that have been urged in regard to the present course of medical study, and to a general survey of the course with a view to the needs of the student who enters upon it either direct from school or after a course in the preliminary sciences at a medical school or university, and who may expect to be fitted to enter upon independent practice of his profession as a general practitioner at its conclusion. The consideration of all questions of special courses of study either for those who enter the profession late or for those who require special or prolonged courses with a view to the practice of some specialty, has not yet been undertaken. Moreover, the specific content of, or field to be covered by, each subject has not been exactly explored; nor are any definite recommendations yet made as to the alterations which would be required in the resolutions or recommendations of the General Medical Council if the suggestions of the Committee were to be adopted and carried into effect. The Committee realizes that it has so far covered only a part of the field of its reference, and if it be reappointed in July it will be its business to deal with many other matters relevant to medical education. It should be understood that all that has at present been attempted is to consider the main object of the course in the case of the ordinary student, degree of preparation which should be expected of the student before entering upon the course, and the general lay-out of the course with a view to satisfying in the best way this mininum requirements. The object has been not to establish any uniform system of teaching in the various medical schools, but to leave the door open to a wide variety of arrangements or teaching methods, provided that certain broad general requirements are satisfied.

The committee in submitting its interim report wishes to draw attention to the fact the opinion of the committee on all the points included in the report was not unanimous and particularly to the fact that there was a somewhat pronounced difference on two matters: (1) whether two and half years was long enough for purposes indicated in paras 20 and 21, and (2) whether it was desirable to include alternative (e) in para 23.

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## REPORT.

### General Aims and Methods of Medical Curriculum.

1. The primary object of the medical curriculum should be to produce on its completion a practitioner who has acquired a right attitude towards professional duties and responsibilities, an ability to deal reasonably in the early days of practice with such patients and conditions as may confront him, and such basic knowledge and mental training as will enable him to profit contiuously by daily experience. It should at the same time constitute such a co ordinated course of study as will, by its mental discipline, make the student a really educated person and not merely a skilled technician.

2. From the beginning of the curriculum and throughout, attention should be directed primarily to health, its preservation, perfection, or restoration and not to disease. A patient would then naturally come to be regarded as a person to be restored to

the normal, if possible, and thought to remain so, rather than as 'an uninteresting vehicle containing some fascinating disease processes.' (Benard Hart.)

3. In general, especially with a view to avoiding any extension of the duration of medical studies prior to graduation or qualification, it is important (*a*) that the Student should start the medical curriculum with adequate and appropriate previous equipment, (*b*) that into whatever stages the medical course be divided these stages shall be regarded as interdependent, (*c*) that the instruction in each stage shall be conducted in direct reference to that which is to succeed it, and (*d*) that it shall be unnecessary to do at any stage what ought to have been done in any of the preceding stages.

## Registration and Pre-Registration Studies.

4. Registration as a medical student should be compulsory ; pre-registration study and examination should include chemistry, physics and biology, and the medical curriculum properly so described should be regarded as commencing with the full study of human anatomy and physiology.

5. The student should have taken at school the General School Certificate Examination, and thereafter, should have followed either at school or at a university or at some place of higher education approved by the university, a further course of study which, in addition to the three science subjects, would include other subjects of general education, usually English language and literature, one foreign language, and perhaps history. Such a course would not necessarily be taken only by those students who were intended for the profession of medicine.

6. The usual duration of such a course would be two academic years. Within such a period it would be possible to ensure for the student of average ability a thorough grounding in physics, chemistry, and biology, while continuing the study of other subjects of general educational value. Representatives of the teaching profession consulted by the committee were unanimously of opinion that it would be advantageous definitely to prescribe the age of 18 years as that below which registration as medical student, under the conditions stated in paragraph 4, should not be allowed ; but they agreed that there are exceptional students who could take the required course and attain the required standard therein less than two years, and also that it was possible, by a system of deliberate cramming, to attain success in the present type of examination in a shorter period or at a slightly lower age. This however, it is desirable to avoid.

7. It is probable that many of the "public schools" commonly so called, both for boys and for girls, are sufficiently equipped for the teaching of physics, chemistry and biology ; that country and municipal secondary schools are equipped for the teaching of physics and chemistry and approximately one-third of these for the teaching of biology also. Biology is being increasingly regarded as a subject which can well be taught in these schools, and year by year an increasing number of them are making provision for this.

8. In the course indicated chemistry would, and even now often does, include sufficient instruction in the chemistry of the carbon compounds to serve as a foundation for the biochemistry to be taken in the course of physiology or in connection with subsequent clinical study.

9. At the end of this course there should be some examination test prior to registration. Such an examination should include as compulsory, at least one general subject in addition to the science subjects, with opportunity to take more than one such subject when the student so desires. It is undesirable to establish any new examination for this purpose; and it seems likely that the Higher School Examinations of the Universities for example, the London University, the Oxford and Cambridge Universities, and the Combined Northern Universities may provide convenient machinery for such a test. Normally these examinations are taken by the student at 18 years of age, two years after the General School Examination. There are a considerable number of groups of subjects which may be taken and within these groups may be designated as principal and subsidiary. For the purpose of a pre-registration examination for medical students it would be necessary to secure an even greater elasticity in the grouping of subject, and to establish a greater uniformity of standard or of syllabus as required by universities under whose auspices the examination is conducted.

10. It should be remembered that it is the universities themselves which prescibe the nature and standard of the examination and the syllabus of study with reference to which it is to be directed. The school form which the pupils enter for this examination are subject to inspection by the universities concerned. With regard to exceptional cases also it should be remembered that universities may exempt from such examination or any part thereof candidates for admission who satisfy them that they have followed courses of study and taken other tests which may safely be accepted as equivalent; and that the General Medical Council is similarly empowered to exempt students in particular circumstances.

11. Assuming that such a course was intelligently constructed and directed and seriously followed, the student should then at least know how to think, how to read with comprehension and reasonable fluency one language besides his own, how to express himself, both in speech and in writing logically and clearly in his own language. He would have been introduced to some great literature, and have some notion of historical sequence and perspective. He would understand scientific method and scientific principles of observation and deduction; and he would have acquired such a knowledge of the main facts or problems of the physical universe and of living organisms as to enable him to pass to the study of the human organism and its environment with interest, intelligence, and profit.

## Anatomy and Physiology.

12. Anatomy and physiology should be taken *pari passu* as interrelated subject and with reference to their subsequent clinical application.

13. Instruction should be by means of:—

(*a*) Lecture, in which the teaching is not merely through the ear, but through the eye also, use being made of diagrams and pictures, the epidiascope, cinematograph, and skiagrams.

(*b*) Dissection of the dead body and the demonstration of dissected specimens.

(*c*) Demonstrations on and examination of living body.

(*d*) Laboratory practice.

(*e*) Demonstrations in the living subjects of abnormal conditions of structure or function.

14. During the course the student should become familiar with the methods of manual examination, and be taught the use of such instruments as the clinical thermometer, the ophthalmoscope, the laryngoscope, the rhinoscope, the otoscope; the estimation of blood pressure; the examination of the blood; and the analysis of secretions.

15. During the course there should be definite consideration of, and instruction in the following matters or subjects in their relation to human anatomy and physiology and their clinical application.

(*a*) Minute structure.

(*b*) Embryology.

(*c*) The principles of genetics.

(*d*) Nutrition and growth.

(*e*) Mental function.

(*f*) Biophysics and biochemistry.

16. Too great demands are made on the student's time in the course of anatomy as at present taught. In view of opinions expressed in previous paragraphs it is clear that for the medical student human anatomy should be regarded and treated as a study of the living rather than of the dead body. Even so, it should be intimately concerned not merely with structure, but with the relation of structure to function and with occasional reference to cases of impairment of function as manifested clinically. Looked at in this way, the dissection of the human cadaver should occupy a different position from that which it has hitherto held in reference to the teaching of anatomy to the medical student. Dissection by the student of every part of the body is unnecessary. The study and demonstration of dissections prepared by experts is of great value. Furthermore, both as regards teaching and as regards examination, while the relative importance of different structures of systems should be thoroughly considered, a knowledge of meticulous detail, such as exact bony attachments of muscles and the relations of the less important arteries, veins and nerves should not be required. In such ways a good deal of time would be saved; the student would be freed from the necessity of much laborious memorizing or learning by rote; and anatomy would be made a more living and practical part of medicine.

17. Similarly, in the course of physiology, a good deal of time might be saved, without essential loss, by releasing the student from the need for preparing all his own histological sections and for preparing and actually carrying out many experiments in laboratory practice.

18. The course of human anatomy and physiology conducted on these lines should occupy not more than five terms.

## Clinical Years.

19. The term immediately following the completion of this course be occupied with the study of (*a*) pharmacology, (*b*) general pathology and elementary bacteriology, including the principles of asepsis and antisepsis. During this term the student should attend in the post-mortem room, receiving practical instruction in the conduct of necropsies, and acting as post mortem clerk in a certain number of cases; and also should receive a practical introduction to the methods of clinical examination.

20. Including the term indicated in para 19, there would be three years and one term of clinical study, the last

portion of which would be conducted as subsequently laid down. During the first period of not less than two years and six months there would be continued instruction in applied anatomy and physiology, biochemistry, and biophysics, and in pathology and therapeutics in connection with the main courses, which would be as follows :—

(*a*) The principles and practice of medicine.

(*b*) Clinical medicine and attendance on general in-patient and out-patient medical practice, including the holding of a medical clinical clerkship for six months, of which at least three should be in hospital wards.

(*c*) The principles and practice of surgery.

(*d*) Clinical surgery and attendance on general in-patient and out-patient surgical dressership for six months, of which at least three should be in hospital wards.

(*e*) Practical instruction in surgical methods, including mechano-therapeutics.

(*f*) The principles and practice of obstetrics and gynaecology.

(*g*) Clinical obstetrics and gynaecology and attendance on such practice for six months, two-thirds of this time being given to midwifery (including ante-natal care, the management of the puerperium, and the care of the new-born infant), and comprising a period of not less than two months spent as a resident pupil in or in connection with a maternity hospital or wards, at least twenty cases of labour being personally attended under adequate supervision during this period.

(*h*) Disease in childhood, including child hygiene.

21. As part of the systematic and clinical instruction, but not necessarily as separate courses, should be included :—



(*a*) Instruction in the administration of anaesthetics, with personal administration under supervision in at least ten cases.

(*b*) Instruction in and attendance on clinical practice in (*i*) acute infectious diseases, (*ii*) tuberculosis, (*iii*) mental abnormalities, (*iv*) skin diseases, (*v*) venereal diseases, (*vi*) diseases of the eye, (*vii*) diseases of the throat, nose, and ear, (*viii*) public health ; these subjects being taught as related to general practice.

22. In every medical school a scheme should be prepared showing how each department can co-operate in the teaching of the preventive aspects of medicine. Steps should be taken by the authorities of each medical school to put such scheme, when finally approved, into operation at the earliest possible moment.

23. At the end of this period of study an examination (written and clinical) would be taken, but full licence to practise independently would not be granted until satisfactory evidence was produced of further clinical experience under supervision and of certain further instruction, over a period of not more than nine months. This period might be occupied in one or other of the following ways :

(*a*) In a resident house appointment in a teaching or other approved hospital in at least two departments of practice.

(*b*) As a definitely appointed clinical assistant in an approved hospital or clinic for a period of not more than three months.

(*c*) As a pupil assistant to an approved general practitioner.

(*d*) As pupil to an approved medical officer of health for a period of three months.

(*e*) In regular attendance at hospital practice in a medical school.

Evidence of adequate instruction during this period in the legal and social obligations of the medical practitioner (for example, medical ethics, medical jurisprudence, the duties of the medical practitioner in relation to national health services and social welfare) would be required.

EXAMINATIONS.

24. At the end of the course of anatomy and physiology there should be an examination, both written and oral, in those subjects.

25. At an interval of not less than twelve months after the examination in anatomy and physiology there should be a further examination in pharmacology, pathology, and bacteriology.

26. At the end of the main period of clinical study the first part of the Final Examination should be held; this examination would include written oral, and clinical tests. On the conclusion of the period of further clinical experience under supervision to be gained before licence to practice is given, the Final Examination would be completed by a clinical and oral test relating directly to this further clinical experience.

## Civil Hospitals in the Presidency.

### PROGRESS OF WORK DURING PAST YEAR

The annual report on the working of Civil Hospitals and Dispensaries in the Madras Presidency for the year 1932 has been published. The following are extracts from the report :—

The total number of medical institutions of all classes working in the presidency at the beginning of the year under report was 1,337 (1,091 in rural areas and 246 in urban areas), 30 new dispensaries were opened, 20 were closed and 10 were transferred to other classes during the year. Thus at the end of the year, there were 1,337 medical institutions (1,089 in rural areas and 248 in urban areas) at work in the Presidency, *i.e.*, 192 State-public, 33 State-special, 494 Municipal and Local Fund, 481 private aided, 90 private non-aided and 47 railway dispensaries.

The total number of in-door patients treated in classes I, III and IV medical institutions of the Presidency during the year was 212,980 (115,262 males, 82,126 females and 15,592 children) as against 207,847 (114,467 males, 78,861 females and 14,519 children) in the previous year. There has been an increase of 2·47 per cent over the number of in door patients in 1931. There were 9,366 deaths during the year and the death-rate was 4 39 per cent as against 4·67 per cent in 1931. The accommodation provided for in-patients, males and females, in hospitals of classes I, II, III and IV was 9,588 beds (5,353 for males and 4,235 for females) excluding 166 beds common for both Europeans and non-Europeans in the Government General Hospital, Madras, which have not been classed under males and females.

The total number of patients treated for communicable diseases was 1,993,072 with 4,437 deaths. The corresponding figures for 1931 were 1,984,966 patients with 4,179 deaths. The diseases which accounted for the larger numbers were malaria, dysentery, influenza and syphilis (primary and secondary). The total number of operations performed in all classes of medical institutions during the year was 527,811 on 521,631 patients. Of these 521,631 were principal and 6,180 secondary operations. The ratio of deaths per cent to total operations works out to 0·56 for 1932 and 0·28 for 1931. The total number of "selected surgical operations" performed during the year under report was 27,624, the corresponding figure for 1931 being

25,812. The percentage of deaths to total selected operations works out 3·29 whereas the same for the previous year was 3·41.

FINANCES

The year 1932 opened with a cash balance of Rs. 23,012 as compared with Rs. 38,274 during 1931. The total receipts amounted to Rs. 80,92,375. The Government contributed Rupees 57,84,437 towards the salaries of medical officers and otherwise. Local fund and municipal contribution amounted to Rs. 12,22,132 and Rs. 3,46,107, respectively, the corresponding figures for the previous year being Rs. 12,25,656 and Rs. 4,54,720, respectively. The public subscribed Rs. 1,10,119. The Government contribution has decreased by Rs. 1,11,815, compared with that of 1931. The total expenditure for the year was Rs. 80,77,283, of which the amount spent on salaries of medical officers, nurses and other staff was Rs. 37,77,701, on medicines and instruments Rs. 11,88,107, on diet of patients Rs. 9,00,462, on buildings including repairs to buildings Rs. 10,85,513 and on miscellaneous charges Rs. 9,35,815. The closing balance at the end of the year was Rs. 6,896.

The new ophthalmic block at the King George Hospital, Vizagapatam, was completed and occupied during the year. On the opening of the new out-patient department at the Government General Hospital, Madras, under the remodelling scheme the Dental department was re-transferred from Royapuram Hospital. The separate police hospitals at Rajahmundry and Salem were amalgamated with the Government hospitals at those places. The X-ray department at the Royapettah hospital was closed during the year. Owing to financial stringency no new schemes were taken up during the year under report. As a measure of retrenchment the appointment of medical practitioners and midwives to subsidized rural dispensaries sanctioned, but not yet opened, was kept in abeyance.

The 'visited dispensary' system previously known as 'dispensary doctor' system which allows a medical officer or practitioner to leave his permanent dispensary where there is not sufficient work to engage him fully, on two fixed days a week at specified hours in order to travel with his appliances to another village or villages close by and render medical aid there, has been working only in six districts and in the Vizagapatam Agency. After observation for a few years I have concluded that this system can be considered satisfactory only in a few exceptional places or with exceptional individuals to work it. It is not proposed, therefore, to extend this method of medical relief as a whole but to employ it only when particular circumstances indicate that it may be used advantageously.

For the first time in the history of the nursing service in this Presidency, the number of qualified nurses who were available for appointments as staff nurses after the examinations held in June and December 1932 were in excess of the number of vacancies available for them. As a measure of retrenchment the stipend awarded to nurse pupils under training in Government hospitals was reduced during the year. At the instance of the Madras Nurses and Midwives Council, a scheme of training and examination of candidates for the vernacular course in midwifery in Government hospitals was sanctioned by Government. The Madras Nurses and Midwives Council have, during the year 1932, recognized four institutions as training centres for midwives for the scheme sanctioned. On 31st December 1932, the Madras Nurses and Midwives Council had on its registers 780 nurses, 1,668 midwives and 7 dhais.

During the year 80,172 normal and 12,176 abnormal labour cases were

conducted by the staff of the various medical institutions in this Presidency, the corresponding figures for the previous year being 140,403 normal and 15,003 abnormal. The decrease in the number of normal labour cases during the year may be due to the fact that the appointments of midwives and medical practitioners to subsidized rural dispensaries sanctioned, but not opened before 3rd March 1932 and the appointments of midwives to existing subsidized dispensaries in which midwives had not been employed till 3rd March 1932, were kept in abeyance.

The total number of persons treated for beri-beri during the year was 16,754 and the number of deaths was 96.

ANTI-LEPROSY WORK.

In view of the successful working of the Group Leprosy scheme sanctioned for two years from 1st May 1931, its continuance has been sanctioned for a further period of two years from 1st May 1933. The year under report is characterized by increased activities and by the organization of an intensive anti-leprosy campaign by social workers in Salem district. Several medical officers, especially those in charge of leprosy clinics, were given training in the treatment of leprosy. About 120 leprosy clinics were opened during the year bringing the total number of such clinics throughout the Presidency to 196.

The awakening of so many in the Salem district to a sense of citizenship and co-operation and the popular enthusiasm that has led to the erection by private donors of leprosy clinics, operating theatres, maternity wards and other needed buildings have been the most striking features of the medical year throughout the Presidency.

With a view to afford greater facilities to Government servants for leprosy treatment, the Government have recognized fourteen additional medical institutions as treatment centres for leprosy during the year.

Many district and taluk boards have not yet realized the utility of the leprosy campaign with the result that several areas where clinics are very essential are yet untouched. It is hoped that the local bodies will soon realize the importance of the survey of leprosy and of propaganda and contribute towards the successful development of the work. An intensive compaign against leprosy can be revived under these heads—Treatment, propaganda, survey, school medical inspection and social service.

The Venereal department of the Government General Hospital, Madras, under Dr. R. V. Rajam, M.B., M.S., has worked satisfactorily. In the course of the year, 6,846 cases were examined and treated at the General Hospital. A little more than 90 per cent of the patients have been treated as out-patients.

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## MEDICO-LEGAL.

### Fee-Splitting and the Law.

At the end of his opening address to the General Medical Council on May 23rd, 1933, the President, Sir Norman Walker, warned medical men that the practice of fee-splitting or dichotomy was an offence against the law as well as against the good feeling of the profession, and that any conviction in the courts would inevitably bring the offender within the jurisdiction of the Council. The present note deals solely with some legal aspects of a practice which is condemned by every right-thinking member of the medical profession. The principle of law, as stated by Halsbury, is that an agent must not, without the knowledge of his principal, acquire any profit or benefit from his agency other than that contemplated by the principal at the time of making the contract of agency. The general practitioner who calls a specialist into consultation on a case is the patient's agent for that purpose, the terms of the contract of agency being that in return for the practitioner's skill and experience in choosing a suitable specialist, and for his services in co-operation with the specialist and his trouble in arranging consultations, the patient pays him a fee either agreed beforehand or reasonable in the circumstances. It is obviously most undesirable that the practitioner should receive or withhold a part of the fee from the specialist without the patient's knowledge, for such a practice would encourage a tendency among advisers to call in, not the best specialist for the purpose, but the man who would hand over to them the largest proportion of his fee.

There seems to be no reason why the law should not deal with medical dichotomists in exactly the same way as it deals with commercial agents who receive secret commissions or bribes. If this view is correct, then a general practitioner who agrees to take part of the consultant's fee commits both a civil wrong against his patient and an offence against the criminal law. It does not even matter whether he is influenced by the bribes to the prejudice of his patient's interest; he is guilty even if his patient does not suffer any harm. When a commercial agent is found to have received a bribe he can claim no commission for the transaction, and becomes liable to pay to his principal not only the amount of the bribe, but also interest at 5 per cent. from the date when he received it. He must also make good any loss his principal has sustained through his breach of duty. In the same way a patient should be able to sue for the return of the fees, he has paid to the general practitioner in respect of the specialist's services and also for that part of the specialist's fee which the general practitioner has wrongfully received. He also has an action for any loss or injury he may have suffered through the transaction and this damage is measured, *prima facie*, by the amount of the bribe. The specialist is, as a guilty party, also liable for these damages, and it seems probably that he would be liable to return the whole of his fee, because the patient would not have employed him but for the bribe. The patient may choose whether he will repudiate the whole contract, or stand by it and obtain such relief as the Court may think fit to give him. If he chooses to repudiate the contract, presumably he has a right to have his whole fee back. In any event, as he is supposed to have suffered damage equal to the amount of the bribe, he can apparently claim this amount from the specialist irrespective of what, if anything, he has recovered from his usual medical attendant.

Dichotomy as a criminal offence may be dealt with as a conspiracy to defraud or under the statute mentioned

by Sir Norman Walker—the Prevention of Corruption Act, 1906. (6 Edward VII, 34). Under Section 1 of the Act it is a misdemeanour punishable with two years' imprisonment, or a fine of £500, or both, for an agent corruptly to accept or obtain any consideration as an inducement to show favour to anyone in relation to his principal's business. It is the same offence to agree to accept such a reward, or to attempt to obtain it, or to give or offer it. Conviction for this offence, as for any other, makes a practitioner liable to have his name erased from the *Medical Register* by the General Medical Council without further inquiry into the facts on which the conviction was based. (*British Medical Journal, 24th June, 1933.*)

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**Compulsory Medical Examination.**

In a recent case at Kolar, Mysore, the Senior Surgeon of Mysore State was summoned by the Court as a court witness. The accused requested that the minor girl be present in the court at the time of the examination of the Senior Surgeon. The public prosecutor agreed to this if there was no medical examination of the girl. The following proceedings will be of interest to all medical practitioners.

The prosecution closed its evidence to-day in the Chintamani kidnapping case. The charge against the accused was that they kidnapped and abducted a girl, on the night of the 21st August last at Chintamani town, in Kolar district.

The court has summoned Dr. S. Subba Roo, Senior Surgeon to the Government of Mysore, to be examined as a court witness.

His Honour said that the accused had addressed a request to summon the girl to be present in court when the senior surgeon was examined.

The Public Prosecutor replied that he would arrange to summon the girl, if it was not for her examination.

His Honour remarked that when the court itself had not powers to subject her to a medical examination, the defence could not do it and that in the present instance though no useful purpose would be served by directing her appearance in court at that stage he did not want to reject a request from the accused.

The court asked the defence counsel whether he could as a matter of right ask for the summoning of the girl when the Senior Surgeon was being examined. Counsel replying in the affirmative, the court asked him to point out the sections under which the request was made.

Defence counsel said that he could not point out any section.

The Court: If you file an application on these lines, I will give my ruling.

Counsel: I have authorities which say that the court could get the girl even medically examined.

Court: Against her will?

Counsel: That it is not mentioned there.

Court: That is the whole point If you have got that right and if you can point out the authority, I am prepared to exercise the right in your favour. But you must point out some provision in the Criminal Procedure Code, if your agrument is to prevail.

Counsel: Nowhere is it stated that the court could not get her so examined.

Court: Should not there be some power for the court whereby it can direct certain things being done? You cannot say that the court has any inherent powers under the Criminal Procedure Code.

Counsel: There is nothing to show that a girl could be medically examined only with consent.

Court: Can I then forcibly send her to Madras?

Counsel: Here the girl is said to be a minor and she could not therefore give a valid consent.

Court: But I am not her guardian.

Counsel: Her father is her guardian.

Court: I do not know. The girl has all along been under police protection. I hope you don't say that the police are her guardians.

The defence counsel persisted in saying that the accused had the right to get the girl medically examined whereupon His Honour exclaimed: "You may have the right to claim many things, but the court must have powers to compel a medical examination.

Counsel: Your Honour may draw an adverse inference from her reprisal.

Court: That is another matter.

The Public Prosecutor remarked that if the girl was examined by a doctor against her will, the doctor was exposing himself to the risk of a criminal prosecution from the parties.

Court: No doctor will care to examine the girl under such circumstances. Do you want the doctor in the present case to undergo that ordeal?

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## Allegations against Assistant Surgeon.

The Government of Assam have appointed a Commission consisting of Khan Bahadur Nasiruddin Ahmed Chowdhury, retired Additional Chief Presidency Magistrate, Calcutta, and Mr. Thomas, I. C. S. of Shillong, to enquire into the conduct of an assistant surgeon and a sub-inspector of police.

The commission has been appointed in consequence of certain strictures passed by the Sessions Judge as to the conduct of the two officers in connection with the exhumation of the body of a Moslem woman from the grave. It is alleged that the assistant surgeon submitted a report, to the effect, that the woman had been the victim of a murder. In acquitting the accused in the murder case, the Sessions Judge remarked: "It came as one of the surprises of my life that the police think it is not beyond their power to influence a medical officer, whose opinion they find is not quite satisfactory for their purpose".

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## Indian Medical Council Act

### Act No XXVII of 1933

[The following Act of the Indian Legislature received the assent of the Governor General on the 23rd September, 1933.—ED.]

WHEREAS it is expedient to constitute a Medical Council in India in order to establish a uniform minimum standard of higher qualifications in medicine for all provinces; It is hereby enacted as follows:—

Short title, extent and commencement.

1. (1) This Act may be called the Indian Medical Council Act, 1933.

(2) It extends to the whole of British India.

(3) It shall come into force on such date as the Governor General in Council may, by notification in the Gazette of India, appoint.

Definitions.

**2.** In this Act, unless there is anything repugnant in the subject or context,—

(*a*) " British Indian University " means any university in British India established by an Act of the Indian Legislature or of a local Legislature and having a medical faculty;

(*b*) " the Council " means the Medical Council of India constituted under this Act;

(*c*) " medical institution " means any institution within or without British India, which grants degrees, diplomas or licences in medicine;

(*d*) "medicine" means modern scientific medicine and includes surgery and obstetrics, but does not include veterinary medicine and surgery;

(*e*) " Provincial Medical Council" means a medical council constituted under an Act of a local Legislature to regulate the registration of medical practitioners;

(*f*) " Provincial Medical Register " means a register maintained under an Act of a local Legislature to regulate the registration of medical practitioners;

(*g*) " recognised medical qualification " means any of the medical qualifications included in the First and Second Schedules; and

(*h*) " Regulation " means a Regulation made under section 18.

Constitution and composition of the Council.

**3.** (1) The Governor General in Council shall cause to be constituted a Council consisting of the following members, namely :—

(*a*) one member from each Governor's province, to be nominated by the Local Government of the province;

(*b*) one member from each British Indian University, to be elected by the members of the Senate of the University (or, in the case of the University of Lucknow, the Court, and in the case of the University of Rangoon, the Council) from amongst the members of the medical faculty of the University;

(*c*) one member from each province where a Provincial Medical Register is maintained, to be elected from amongst themselves by persons enrolled on the Register, who possess recognised medical qualifications or medical qualifications granted by a British Indian University; and

(*d*) three members to be nominated by the Governor General in Council.

(2) The President of the Council shall be elected by the members of the Council from amongst themselves:

Provided that for four years from the first constitution of the Council the President shall be a person nominated by the Governor General in Council who shall hold office during the pleasure of the Governor General in Council and, where he is not already a member, shall be a member of the Council in addition to the members prescribed in sub-section (1).

(3) No act done by the Council shall be questioned on the ground merely of the existence of any vacancy in, or any defect in the constitution, of the Council.

Mode of election.

**4.** (1) An election under clause (*b*) or clause (*c*) of sub-section (1) of section 3 shall be conducted by the Local Government, in such

manner as it may think fit, subject to any instructions the Governor General in Council may issue in this behalf.

(2) Where any dispute arises regarding any election to the Council it shall be referred to the Local Government whose decision shall be final.

Restrictions of nominations and elections.

5. (1) No person shall be eligible for nomination or election under clause (*a*) or (*b*) of sub-section (1) of section 3 unless he possesses a recognised medical qualification or a medical qualification granted by a British Indian University.

(2) No person shall be eligible for nomination under clause (*a*) of sub-section (1) of section 3 unless he resides in the province concerned, and, where a Provincial Medical Register is maintained in that province unless he is enrolled on that register.

(3) No person shall be eligible for election under clause (*b*) of sub-section (1) of section 3 unless he has had at least four years' experience as a Professor, Assistant Professor, Lecturer or Reader in Medical Colleges or Schools.

(4) No person may at the same time serve as a member in more than one capacity.

Incorporation of the Council.

6. The Council so constituted shall be a body corporate by the name of the Medical Council of India, having prepetual succession and a common seal, with power to acquire and hold property both movable and immovable, and to contract, and shall by the said name sue and be sued.

Term of office.

7. (1) An elected President shall hold office for a term not exceeding five years and not extending beyond the expiry of the term for which he has been nominated or elected to be a member of the Council.

(2) A member, other than a nominated President, shall hold office for the term of five years from the date of his nomination or election or until his successor shall have been duly nominated or elected, whichever is longer.

(3) Where the said term of five years is about to expire in respect of any member, his successor may be nominated or elected at any time within three months before the said term expires, but shall not assume office until the said term has expired.

Meeting of the Council.

8. (1) The Council shall hold its first meeting at such time and place as may be appointed by the Governor General in Council; and thereafter the Council shall meet at least once in each year at such time and place as may be appointed by the Council.

(2) Until otherwise provided by Regulations, ten members of the Council shall form a quorum, and all the acts of the Council shall be decided by a majority of the members present and voting.

Officers, Committees and servants of the Council.

9. (1) The Council shall—

(*a*) elect from amongst its members a Vice-President;

(*b*) constitute from amongst its members an Executive Committee, and such other Committees for general or special purposes as the Council deems necessary to carry out the purposes of this Act;

(*c*) *appoint a Secretary, who may also, if deemed expedient, act as Treasurer;

(*d*) appoint or nominate such other officers and servants as the Council deems necessary to carry out the purposes of this Act;

(*e*) require and take from the Secretary, or from any other officer or servant, such security for the due performance of his duties as the Council deems necessary; and

(*f*) with the previous sanction of the Governor General in Council, fix the remuneration and allowances to be paid to the President, Vice-President, members, officers and servants of the Council.

(2) Notwithstanding anything contained in clause (*c*) of sub-section (1), for the four years from the commencement of this Act, the Secretary of the Council shall be a person appointed by the Governor General in Council, who shall hold office during the pleasure of the Governor General in Council.

The Executive Committee.

**10.** (1) The Executive Committee shall consist of seven members, of whom five shall be elected by the Council from amongst its members.

(2) The President and Vice-President of the Council shall be members ex-officio of the Executive Committee, and shall be President and Vice-President, respectively, of that Committee.

(3) In addition to the powers and duties conferred and imposed upon it by this Act, the Executive Committee shall exercise and discharge such powers and duties as the Council may confer or impose upon it by any Regulations which may be made in this behalf.

Recognition of medical qualifications granted by medical institutions of British India.

**11.** (1) The medical qualifications granted by medical institutions in British India which are included in the First Schedule shall be recognised medical qualifications for the purposes of this Act.

(2) Any medical institution in British India which grants a medical qualification not included in the First Schedule may apply to the Governor General in Council to have such qualification recognised, and the Governor General in Council, after consulting the Council, may, by notification in the Gazette of India, amend the First Schedule so as to include such qualification therein.

(3) Such notification may also direct that an entry shall be made in the last column of the First Schedule against such medical qualification declaring that it shall be a recognised medical qualification only when granted after a specified date.

(4) The Council shall, as soon as may be and without application being made, make all necessary arrangements for the inspection of the medical courses and examinations of the Universities of Patna, Rangoon and Andhra, and shall submit their recommendations to the Governor General in Council regarding the inclusion in the First Schedule of the medical qualifications granted by these Universities.

Non-Indian qualifications in Second Schedule to be recognised.

**12.** The medical qualifications granted by medical institutions outside British India which are included in the Second Schedule shall be recognised medical qualifications for the purposes of this Act, and shall be sufficient qualification for enrolment on any Provincial Medical Register.

**13.** (1) At any time during the period of four years after the commencement of this Act, the Council may enter into negotiations with the authority in any State or country outside British India which is entrusted by the law of such State or country with the maintenance of a register of medical practitioners, for the settling of a scheme of reciprocity for the recognition of medical qualifications, and the course of such negotiations shall be reported to the Governor General in Council, along with the decisions of the Council to recognise or to refuse to recognise the medical qualifications proposed by such authority for recognition in British India.

Transitory arrangements for modifying the Second Schedule.

(2) In so far as the decisions of the Council to recognise medical qualifications are accepted by the Governor General in Council, they shall be embodied in a resolution and published in the Gazette of India, and such resolution shall specify or indicate with sufficient accuracy all medical qualifications finally approved for recognition in British India:

Provided that where any such resolution specifies or indicate a medical qualification which is not included in the Second Schedule, the Governor General in Council may, by notification in the Gazette of India, amend the Second Schedule so as to include such qualification therein, and such amendment may further direct that such qualification shall be deemed to be a recognised medical qualification for the purposes of this Act only when granted after a specified date.

(3) Within one month before the expiry of the period of four years from the commencement of this Act, the Governor General in Council shall frame a schedule to include all medical qualifications which have been specified or indicated by him in resolutions made under sub-section (2), and shall publish the said schedule in the Gazette of India, and such schedule shall be substituted for the Second Schedule with effect from the expiry of the said period of four years, and shall then have force as if it had been enacted in this Act:

Provided that the Governor General in Council shall include in the said schedule all medical qualifications included in the Second Schedule which were granted before the expiry of the said period of four years.

**14.** (1) At any time after the expiry of the period of four years after the commencement of this Act, the Council may complete or may enter into negotiations with the authority in any State or country outside British India which by the law of such State or country is entrusted with the maintenance of a register of medical practitioners, for the setting of a scheme of reciprocity for the recognition of medical qualifications, and in pursuance of any such scheme the Governor General in Council may, by notification in the Gazette of India, amend the Second Schedule so as to include therein any medical qualification which the Council has decided should be recognised.

Permanent arrangements modifying the Second Schedule.

(2) Such notification may also direct that an entry shall be made in the last column of the Second Schedule against such medical qualification declaring that it shall be a recognised medical qualification only when granted after a specified date.

(3) The Governor General in Council, after consultation with the Council, may, by notification in the Gazette of India, amend the Second Schedule by directing that an entry be made therein in respect of any medical qualification,

declaring that it shall be a recognised medical qualification only when granted before a specified date.

(4) Where the Council has refused to recognise any medical qualification which has been proposed for recognition by any such authority, that authority may, apply to the Governor General in Council, and the Governor General in Council, after considering such applications and after consulting the Council, may, by notification in the Gazette of India, amend the Second Schedule so as to include such qualification therein, and the provisions of sub-section (2) shall apply to such notification.

**15.** Every medical institution in British India which grants a recognised medical qualification shall furnish such information as the Council may, from time to time, require as to the courses of study and examinations to be undergone in order to obtain such qualification, as to the ages at which such courses of study and examinations are required to be undergone and such qualification is conferred, and generally as to the requisites for obtaining such qualification.

Power to require information as to courses of study and examinations.

**16.** (1) The Executive Committee shall appoint such number of medical inspectors as it may deem requisite to attend at any or all of the examinations held by medical institutions in British India for the purpose of granting recognised medical qualifications.

Inspection of examinations.

(2) Inspectors appointed under this section shall not interfere with the conduct of any examination, but they shall report to the Executive Committee on the sufficiency of every examination which they attend and on any other matters in regard to which the Executive Committee may require them to report.

(3) The Executive Committee shall forward a copy of any such report to the medical institution concerned, and shall also forward a copy, with the remarks of such institution thereon, to the Governor General in Council.

**17.** (1) When, upon report by the Executive Committee, it appears to the Council that the courses of study and examination to be gone through in any medical institution in British India in order to obtain a recognised medical qualification or that the standards of proficiency required from candidates at any examination held for the purpose of granting such qualification are not such as to secure to persons holding such qualification the knowledge and skill requisite for the efficient practice of medicine, the Council shall make a representation to that effect to the Governor General in Council.

Withdrawal of recognition.

(2) After considering such representation, the Governor General in Council may send it to the Local Government of the province in which the medical institution is situated, and the Local Government shall forward it, along with such remarks as it may choose to make, to the medical institution, with an intimation of the period within which the medical institution may submit its explanation to the Local Government.

(3) On the receipt of the explanation or, where no explanation is submitted within the period fixed, then on the expiry of that period, the Local Government shall make its recommendations to the Governor General in Council.

(4) The Governor General in Council, after making such further inquiry

if any, as he may think fit, may, by notification in the Gazette of India, direct that an entry shall be made in the First Schedule against the said medical qualification declaring that it shall be a recognised medical qualification only when granted before a specified date.

Power to make Regulations.

**18.** (1) The Council may, with the previous sanction of the Governor General in Council, make Regulations generally to carry out the purposes of this Act, and without prejudice to the generality of this power, such Regulations may provide for—

(*a*) the management of the property of the Council;

(*b*) the summoning and holding of meetings of the Council, the times and places where such meetings are to be held, the conduct of business thereat and the number of members necessary to constitute a quorum;

(*c*) the resignation of members of the Board and the filling of casual vacancies;

(*d*) the powers and duties of the President and Vice-President;

(*e*) the mode of appointment of the Executive Committee and other Committees, the summoning and holding of meetings, and the conduct of business of such Committees.

(*f*) the tenure of office, and the powers and duties of the Secretary and other officers and servants of the Council;

(*g*) the appointment, powers, duties and procedure of medical inspectors; and

(*h*) any matter for which under this Act provision may be made by Regulations.

(2) Until the first Council is constituted under this Act, any Regulations which may be under sub-section (1) may be made by the Governor General in Council; and any Regulation so made may be altered or rescinded by the Council in exercise of its powers under sub-section (1).

Information to be furnished by Council, and publication thereof.

**19.** (1) The Council shall furnish such reports, the copies of its minutes, abstracts of its accounts, and other information to the Governor General in Council as he may require.

(2) The Governor General in Council may publish, in such manner as he may think fit, any report, copy, abstract or other information furnished to him under this section or under section 16.

Commissions of Inquiry.

**20.** (1) Whenever it is made to appear to the Governor General in Council that the Council is not complying with any of the provisions of this Act, the Governor General in Council may refer the particulars of the complaint to a Commission of Inquiry consisting of three persons, two of whom shall be appointed by the Governor General in Council, one being a Judge of a High Court established by Letters Patent of the Crown, and one by the Council; and such Commission shall proceed to inquire in a summary manner and to report to the Governor General in Council as to the truth of the matters charged in the complaint, and in case of any charge of default or of improper action being found by the Commission to have been established, the Commission shall recommend the remedies, if any, which are in its opinion necessary.

(2) The Governor General in Council may require the Council to adopt the remedies so recommended within

such time as, having regard to the report of the Commission, he may think fit; and if the Council fails to comply with any such requirement, the Governor General in Council may amend the Regulations of the Council, or make such provision or order or take such other steps as may seem necessary to give effect to the recommendations of the Commission.

(3) A Commission of Inquiry shall have power to administer oath, to enforce the attendance of witnesses and the production of documents, and shall have all such other necessary powers for the purpose of any inquiry conducted by it as are exercised by a Civil Court under the Code of Civil Procedure, 1908.

## THE FIRST SCHEDULE. (*See* section 11).

*Recognised medical qualifications granted by medical iustitutions in British India.*

| Medical Institution. | Recognised medical qualification. | Abbreviation for Registration. |
|---|---|---|
| University of Allahabad ... | Bachelor of Medicine and Bachelor of Surgery. | M.B., B.S., All. |
| University of Bombay ... | Licentiate in Medicine and Surgery ... | L.M.S., Bom. |
| | Bachelor of Medicine and Bachelor of Surgery | M.B., B.S., Bom. |
| | Doctor of Medicine ... ... ... | M.D., Bom. |
| | Master of Surgery ... ... ... | M.S., Bom. |
| University of Calcutta ... | Licentiate in Medicine and Surgery ... | L.M.S., Cal. |
| | Bachelor of Medicine ... ... ... | M.B., Cal. |
| | Doctor of Medicine ... ... ... | M.D., Cal. |
| | Master of Surgery ... ... ... | M.S., Cal. |
| | Master of Obstetrics ... ... ... | M.O., Cal. |
| University of Lucknow ... | Bachelor of Medicine and Bachelor of Surgery. | M.B., B.S., Lucknow. |
| University of Madras ... | Licentiate in Medicine and Surgery ... | L.M.S., Mad. |
| | Bachelor of Medicine and Master of Surgery. | M.B., C.M., Mad. |
| | Bachelor of Medicine and Bachelor of Surgery. | M.B., B.S., Mad. |
| | Doctor of Medicine ... ... ... | M.D., Mad. |
| Punjab University ... | Licentiate in Medicine and Surgery ... | L.M.S., Pun. |
| | Bachelor of Medicine ... ... ... | M.B., Pun. |
| | Doctor of Medicine ... ... ... | M D., Pun. |
| | Master of Surgery ... ... ... | M.S., Pun. |

## THE SECOND SCHEDULE. (*See* section 12).

*Recognised medical qualifications granted by medical institutions outside British India.*

A. Registrable qualifications admitting primarily to the Medical Register granted by licensing bodies in the United Kingdom, as shown in Table (F) set out in the Medical Register for 1931 printed and published under the direction of the General Council of Medical Education and Registration of the United Kingdom in pursuance of the Medical Acts, 1858 and 1886.

(B) Registrable qualifications granted by licensing bodies in British possessions, as shown in Table (I) set out in the said Medical Register, other than registrable qualifications granted by licensing bodies in India.

(C) Registrable qualifications granted by licensing bodies in Foreign Countries, as shown in Table (J) set out in the said Medical Register.

## Associations

### ALL-INDIA MEDICAL CONFERENCE.

*Forthcoming Session in Bombay*

Mr. K. S. Ray, Joint Honorary Secretary, Indian Medical Association, writes :—

The Tenth All-India Medical Conference will be held at Bombay during the ensuing Christmas week. The dates of the Conference as provisionally fixed are 27th, 28th and 29th December 1933. Invitations are extended on behalf of the Reception Committee formed at Bombay to all the members of the medical profession and medical associations all over India. Dr G. V. Deshmukh, M.D. (Lond.), F.R.C.S. (Eng.), of Bombay has been elected Chairman of the Reception Committee and Dr. M. A. Ansari, M.D., F.R.C.S. has been elected President of the Conference.

As on previous occasions, this Conference will consider many important problems affecting the vital interests of the medical profession of India. There will be a Scientific Section where scientific papers will be read and discussion on interesting case notes will take place. Those members desirous of taking part in the Scientific Section are requested to send a synopsis of the paper which they intended to read either to me at the address given below or to Dr. V. N. Khanolkar (Bombay), Chairman, Scientific Sub-Committee, Tenth All-India Medical Conference, Bombay, by the 15th of November. Papers read at the Scientific Section of the Conference will be published in the official journal of the Indian Medical Association and may not be published in any other paper wtthout the sanction of the Journal Committee.

There will be an Exhibition of Medical and Scientific Product along with the Conference. Intending exhibitors desiring to book stalls are requested to communicate with Dr. K. K. Dadachanji, Bombay, Chairman, Exhibition Sub-Committee.

Owing to shortness of time it has not been possible to extend invitations individually to members of the profession all over India. It is hoped a large number of delegates will attend the Conference to help the deliberations and take part in the Scientific Section. The delagation fee has been fixed at Rs. 5.

The Conference is open to medical men in Government service and there is nothing to hinder their attendance. Their participation will be welcomed, particularly in the Scientific Section, in view of the great assistance such men are usually in a position to give.

Delegates intending to attend the Conference are requested to communicate with Dr. D. D. Sathaye, F.R F.P S., Secretary, Reception Committee, Tenth All-India Medical Conference, 127, Girgaum Road, Bombay 4, for accommodation, etc.

### THE TRICHINOPOLY DISTRICT MEDICAL ASSOCIATION.

A monthly Meeting of the Trichinopoly District Medical Association (Registered), was held in the Government Hospital, Srirangam, when about 40 doctors were present. In the unavoidable absence of Lt.-Col. N. M. Mehta, I.M.S., Dr. T. V. Swaminatha Shastry, presided.

Drs. S. Janaky, M. S. Kuppuswami Iyer, and K. A. Chidambara Iyer, were "At Home."

Dr. K. A. Chidambara Iyer demonstrated from the Hospital a case of infective granuloma of the pudenda which was resistant to treatment, and

Dr. Kuppuswami Iyer, a case of diabetic-cellulitis of the leg cured without amputations.

Dr. T. S. S. Rajan, showed a specimen of an excised uterus with a tumour which he had removed a few days back and gave case notes on the same.

Dr. R. Sambhasivan, read an interesting paper on "Nutrition", aided with charts and statistics.

Dr. P. A. S. Raghavan, the Secretary then brought forward a resolution that the Annual-Gathering which comes off in December be made into a medical Conference of the Southern Districts and that a number of doctors be invited to deliver lectures, read papers and have discussions. This was unanimously carried.

With a vote of thanks to the Chair and the Hosts and Hostess the meeting terminated.

### East Godavari Medical Association.

### Meeting at Peddapuram.

The monthly meeting of the East Godavari District Medical Association, Cocanada, was held this time at Peddapuram on the 11th instant. 50 doctors from all over the District attended the function. Among those present on the occasion were Messrs. K. Kalyanaswami retired Sub-Judge, Cocanada, G. Krishnamurti, District Munsif, Peddapuram and Lieut, P. Papatla, D.O.M.S., (Lond.), F.R.C.S. (Edin.), I.M.S., Eye Specialist to the Military Hospitals, Bangalore, on leave. Major T. S. Shastry, I. M. S., presided.

After a tea-party, the proceedings commenced at 5 p.m. with delightful music by a young boy. Some interesting cases from the Peddapuram area were exhibited by the local doctors.

Major Shastry exhibited a case of vaginal Hysterectomy done by him recently with very good results. He gave a short lecture on "Spinal Tuberculosis" exhibiting a series of skiagrams of a case which was doing well in the Government Hospital at Cocanada. He dwelt at length on the treatment adopted in this case which was the same as that of Professor Rollier of Leysin, Switzerland, in his sanatorium for surgical tuberculosis which he had the good fortune to visit some time back.

The treatment, he said, consisted mainly in putting all such cases at rest in bed, not in the old fashioned supine position on the back with extension, plaster of paris jackets and other cumbersome and costly appliances, but merely in the prone position, the patient facing the bed and resting on his abdomen and knees and forearms. He saw in a short time the patient came to love this position, the temperature came down, pain subsided, the curvature corrected itself and the back muscles were getting athletically developed and acting as natural splints to the diseased spine. The patients in that position could do anything they pleased with their hands and feet by way of playing on musical instruments, reading, typewriting, painting, etc., by way of hobby. He also said that Professor Rollier used exposures to sunlight in his treatment but that such course might not be necessary or feasible in this country where there was plenty of sunlight always streaming into well-ventilated sheds.

Lieut. Papatla, I.M.S., on request delivered a lecture on external eye-disease in general wherein he made a rapid survey of all diseases mentioning the latest treatment and warning the general practitioners against hasty

diagnosis leading to such blunders as a case of glaucoma being mistaken for a case of cataract and the patient asked to wait for maturity and the waiting ending in blindness and emphasising the value of a systematic examination to be done as a routine in any eye cases.

Dr. Chelapati Rao, Ramachandrapuram, read a paper on the training of country dhais.

Major Shastry wound up the proceedings saying he was sorry that some subject on the agenda had to be postponed for want of time and thanking the guest and the organisers and especially Dr. Papatla for his masterly discourse on the disease of the eye.

After flute music and dinner, the guest dispersed.

TANUKU MEDICAL ASSOCIATION.

The 3rd anniversary of the Tanuku Medical Association and the 3rd Bi-monthly meeting of the West Godavary District Medical Association was held on Saturday the 11th November, 1933 at Tanuku at Dr. Ch. Sathiraju's upstairs. Nearly 80 Medical Practitioners from all over the District attended the function. Dr. V. Sreenivasa Rao, M.B.C.M., District Medical Officer, West Godavary, was voted to the chair. The Secretary of the Tanuku Medical Association read an interesting report on the activities of the Association during the year 1932. The nature of the constitution for the District Medical Association was then discussed at length and a Federal type of constitution was voted for by a majority of 25 against 16. Refreshments were served on a grand scale after which interesting papers were read on "The use of Mercurochrome in Medicine and Surgery" by Dr. V. Purnarao, "The Senile cataract" by Dr. E. Dilshitilu, "Optimism in medicine" by Dr. Ch. S. John which were supplemented by valuable discussions by some of the members present. The function came to a successful termination with a vote of thanks to the President and the Host. All the members present were entertained at a Dinner that night by Dr. Ch. Sathiraju.

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## Madras Legislative Council.

*Questions and Answers.*

IMPROVEMENTS IN GOSHA HOSPITAL.

The following were among the questions put and answered in the Council:—

*Q.*—Mr. Basheer Ahmed Sayeed: Will the hon. the Minister for Local Self-Government be pleased to state—(*a*) whether there are any proposals before the Government for improvements to the Victoria Caste and Gosha Women's Hospital, Madras; (*b*) if so, what they are, for how long they have been pending and what their total cost is; (*c*) whether the Government propose to provide for the required funds in the next budget estimates; and (*d*) if so, to what extent and for what purpose?

*A.*—(*a*) Yes. There is a combined scheme for improvements to the hospital and for the construction of a Medical School and Hostel for women in Madras; (*b*) The main items of work included in the scheme are :—(1) Additional wards for 124 beds, (2) Out-patient department, (3) Laundry, (4) Cow-shed, (5) Additions to the existing delivery room (this work has been taken up for execution), (6) Medical school block, (7) Dissection block, (8) Hostel for 160 students, (9) Quarters for Indian nurses, (10) Superintendent's quarters, (11) Matron's

quarters. The total cost of the scheme which has been pending since 1925, as finally revised is estimated at Rs. 15·10 lakhs. (*c*) and (*d*) The Government are considering the question of providing a sum of Rs. 76,000 for the construction of the out-patient department.

Mr. Basheer Ahmed asked whether Government would consider the provision of adequate funds in the next year's budget in view of the fact that the scheme had been pending since 1925.

The hon. the Raja of Bobbili : The answer states that the Government are considering the question of providing a sum of Rs. 76,000 in the next year's budget.

Sir A. P. Patro : Will the Government consider the necessity or desirability of separating the improvement scheme from other items, so that the former might be taken on hand and pushed through ?

The answer was to the effect that that scheme was being considered separately.

Mr. Hameed Khan asked whether the name of the Hospital had been changed and if so what its present name was ?

*A.*—The question, I think, does not arise.

Dr. C. Natesa Mudaliar: Is the Government aware of the urgent necessity for constructing an out-patients department ?

*A.*—That is why they are considering the question of improvements and increase of accommodation.

Mr. Basheer Ahmed : In view of the fact that Rs. 76,000 has been provided by way of a supplementary budget, may I know what amount is to be provided in the next year's budget ?

*A.*— Rs. 76,000 is the amount to be provided in the next year's budget.

Mr. V. T. Arasu : Is it a fact that several patients are allowed to sleep on the verandah for want of accommodation inside the hospital ?

*A.*—It is a fact.

Dr. C. Natesa Mudaliar : Will this provision of Rs. 76,000 be taken up for the construction immediately ?

*A.*—This provision is proposed to be made in the budget for 1934-35.

Mr. V. T. Arasu : Is it proposed to have a Children's Hospital as an adjunct to this hospital and if so where is it to be located ?

The answer was to the effect that Children's block would form part of the Hospital in the same compound.

THE GOSHA HOSPITAL.

*Q.*—Mr. Basheer Ahmed Sayeed : Will the hon. the Minister for Local Self-Government be pleased to state—(*a*) whether any scheme and estimate for a new out-patient department in the Victoria Caste and Gosha Women's Hospital, Madras, have been received by the Government ; (*b*) if so, when were the same received and at what stage the estimate is; and (*c*) when the same will be sanctioned and what the total cost of the estimate is ?

*A.*—(*a*) Yes ; (*b*) and (*c*) The proposal which was received by the Government in July last is being considered in connection with the Civil Budget Estimate for 1934-35. The total cost of the scheme is estimated at Rs. 76,000.

Mr. Basheer Ahmed asked whether there was any provision for improvements to the out-patient department.

*A.*—There are a number of schemes. It has been possible to make provisions for all of them in this year's Budget.

OPENING OF BIRTH-CONTROL CLINICS.

*Q.*—Mr. A. B. Shetty: Will the hon. the Minister for Local Self-Government be pleased to state—(*a*) whether the Government have considered the question of starting birth-control clinics as promised by the hon. Minister in his reply to the budget debate on the Public Health Demand; and (*b*) if so, what action they propose to take in the matter?

*A.*—The matter is under the consideration of the Government.

Mr. V. T. Arasu asked if it was the intention of the Government to compel everyone to adopt Birth-control.

The hon. the Raja of Bobbili replying said that on a former occasion he had answered several questions on this subject and he did not think he had anything further to add to those answers.

AYURVEDIC AND UNANI DISPENSARIES IN RURAL AREAS.

*Q.*—S. M. K. Beyabani Sahib Bahadur: Will the hon. the Minister for Local Self-Government be pleased to state—(*a*) the number of Unani, Ayurvedic and Siddha dispensaries in the Presidency under the local boards, Municipalities and the Government; (*b*) the number of Registrars and Inspectors appointed recently and how many of them are Muslims; and (*c*) how many qualified Muslims had applied for the above posts?

*A.*—(*a*) There are 6 Unani, 180 Ayurveda and 25 Siddha dispensaries under local boards; 11 Unani, 38 Ayurveda and 8 Siddha dispensaries under Municipalities including the Madras City; and 1 Ayurveda dispensary under Government. (*b*) Two Medical Registrars and two Inspecting Medical Officers. There is no Muslim among them. (*c*) Twelve qualified Muslims applied for the posts of Inspecting Medical Officers. No qualified Muslim applied for the posts of Medical Registrars.

*Q.*—S. M. K. Beyabani Sahib Bahadur: Will the hon. the Minister for Local Self-Government be pleased to state—(*a*) the number of Government Unani, Ayurvedic and Siddha dispensaries in the Presidency; (*b*) the number of Registrars and Inspectors of Unani, Ayurvedic and Siddha dispensaries recently appointed by Government and how many of them are Muslims; and (*c*) how many qualified Muslims had applied for the post?

*A.*—(*a*) (*b*) and (*c*) The attention of the Hon. member is invited to the answer to question No. 424.

Mr. Beyabani Saheb asked if the Selection Committee recommended any names from among Mahomedan candidates to the post of Inspectors.

The Raja of Bobbili answered that one name was recommended.

Mr. Hameed Khan asked whether an Inspector conversant only with Ayurveda and Siddha systems of medicine would be competent to inspect Unani institutions efficiently?

*A.*—I think he would be able to do it.

In replay to a further question, the Raja of Bobbili said that only two appointments had to be made; and as the number of unani dispensaries was only 17, no separate inspector was considered necessary.

Mr. Hameed Khan asked whether the Government would not create one more post.

*A.*—The Government will consider it, when funds are available.

*Q.*—Will it not be possible to consider it in connection with the next budget?

*A.*—Yes.

*Q.*—Diwan Bahadur A. Appadurai Pillai : Will the hon. the Minister for Local Self-Government be pleased to state—(*a*) whether four new posts were recently added to the cadre of the Government School of Indian Medicine —two Registrars and two Inspectors of Dispensaries ; (*b*) whether applications were invited from qualified candidates ; (*c*) whether final appointments have been made; (*d*) whether qualified Indian Christian candidates applied for the posts, if so, for what posts, and whether they were interviewed by the Selection Board ; and (*e*) whether any of the Indian Christians has been appointed, and if not, why not ?

*A.*—(*a*) The Government have sanctioned the appointment of two Medical Registrars and two Inspecting Medical Officers in the Indian Medical School and Hospital, for a period of two years. (*b*) and (*c*) Yes. (*d*) and (*e*) No qualified Indian Christian candidate applied for appointment as Medical Registrar. Only two qualified Indian Christian candidates applied for appointment as Inspecting Medical Officers. Of these only one appeared for the interview held by the Selection Committee. He was not appointed as he was not recommended by the Committee.

Mr. Appadurai Pillai : When will an Indian Christian be appointed ?

*A.*—It will be considered when next the Selection was to be made.

Mr. Basudev : Will the Minister consider the claims of the depressed classes ?

There was ironical laughter and Sir A. P. Patro interjected (hear, hear).

SCHEME OF PROTECTED WATER SUPPLY TO MANGALORE TOWN

*Q.*—Mr. A. B. Shetty : Will the hon. the Minister for Local Self-Government be pleased to State—(*a*) whether the Director of Public Health has been drawing the attention of the Government to the prevalence of enteric fever as an endemic disease in Mangalore and the need for protected water-supply to the town ; (*b*) whether the Hassamar Valley scheme has been abandoned on the ground that the supply is inadequate for the town; (*c*) whether any other scheme is proposed to be investigated ; and (*d*) what further action the Govment propose to take in the matter ?

*A.*—(*a*) The Director of Public Health has pointed out the need for a protected water-supply to the town in order to reduce the incidence of mortality from enteric fever ; (*b*) to (*d*) the Hassamar Valley scheme has not been abandoned. In June 1928, the Municipal Council was asked to report whether it accepted the proposals of Government for the financing of scheme. As no final reply was received from the Council the papers were recorded.

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## APPOINTMENTS

### Clinical Assistants.

*Coimbatore headquarters hospital.*

Dr. R. Ramachandra Rao, B. A., M. C. P. S.

Dr. T. K. Narayanan, L. M. P.

*Ramnad headquarters hospital.*

Dr. S. K. Thirunavakkarasu, L. M. P.

*Virudunagar hospital.*

Dr. M. Palaniyappan, L.M.P.

*Sivaganga hospital.*

Dr. P. K. Menon, M. B. B. S.

*Ongole hospital.*

Dr. C. Ramakrishna, L M. & S.

### Ophthalmic Clinical Assistants.

*Vellore headquarters hospital.*

Dr. S. Venkatasubbayya, L. M. P.

*Conjeevaram hospital.*

Dr. A. Chandramowli, M. B. B. S., B. S. SC.

BULLETIN
OF THE
SOUTH INDIAN MEDICAL ASSOCIATION.

DECEMBER 1933.

## Sacral Anaesthesia.

By P. Govinda Rao, M.B., B.S.,

*Honorary Assistant Surgeon, Royapuram Hospital, Madras.*

Sacral anaesthesia or caudal block is the analgesia obtained by the injection of local anaesthetics into the sacral canal. It is extra-dural anaesthesia, *i.e.*, the anaesthetic is distributed outside the dura-mater as differentiated from spinal or intra-dural anaesthesia, and the anaesthetic solution comes into contact with the nerve roots after they escape from the spinal dura acquiring as they do so, an investment of that membrane. As Hartel remarks, this method of anaesthesia is really a perineural block and the caudal or sacral block is rightly applied to it.

Cathelin in 1901 was the first to investigate the possibility of producing surgical anaesthesia by introducing an anaesthetic solution extra-durally. He used cocaine and produced anaesthesia of the whole body of a dog with 3 c.c. of 1 per cent solution. In the human subject, he injected through the sacral hiatus into the sacral canal, but was unable to produce satisfactory results with safe quantities of anaesthetic. To Stockel and Lowen belong the credit of modifying Cathelin's method and making it useful and safe for human subjects. Schlimpert and Schneider, two gynaecologists, have sought to extend the field of epidural anaesthesia into a sacral anaesthesia by increasing markedly the quantity of the solution used, thus making it a fair rival to spinal anaesthesia.

*Anatomy.*—The dural sac containing the cerebrospinal fluid terminates at the level of the second or third sacral vertebra. Below that level the sacral canal is filled only with sacral nerve roots covered by strong dural sheaths. The sacral canal terminates below in the hiatus sacralis, a triangular opening with the base towards the gluteal cleft bounded on either side by the sacral and coccygeal cornua and at the apex by the termination of the sacral crest (the crest formed by the fusion of the spinous processes of the sacrum). This opening is found at a position slightly higher than the extremity of the gluteal cleft. It varies in sizes. It may be greatly enlarged by the spine of the fourth sacral vertebrae also being bifid, or may be reduced in size by an osseous bar or even entirely closed by osseous changes in the membrane covering it. The hiatus is normally closed by the posterior sacro-coccygeal ligament. By passing the finger along the spines of the sacrum from above downwards the membrane covering the sacral hiatus is readily palpated. Lowen has aptly compared the sensation produced when this membrane is palpated with that of a fontanelle. Even in fat persons this membrane can be made out with sufficient distinctness making it unnecessary to exclude such individuals from this method of anaesthesia.

*Patient's position during injection.*—The most convenient position usually adopted is the one with the patient lying flat on his stomach with a pillow underneath the pelvis to raise the sacral region and render landmarks more accessible. Sims' position or the left lateral position with the knees well drawn up and the knee chest position have also been recommended as suitable when making the injection into the sacral hiatus. The knee chest position is useful for high sacral anaesthesia.

*Solution used.*—Ordinarily a plain 2 per cent solution of novocaine is used for the injection and about 25 to 30 c.c. of it is employed. Lowen recommends the addition to the novocaine solution of 2½ grains of soda bicarb and 1½ grains of sodium chloride to each ounce of the fluid, as Cross in his investigations has found that the addition of soda bicarb causes quicker diffusion into the nerve sheaths. All solutions prior to being used are well sterilised and to each ounce of the solution, five minims of 1 in 1000 liq. adrenalin are added.

*Technique.*—The sacral hiatus situated about one inch to one and half inches above the tip of the coccyx, and the sacral cornua are recognised, and an ordinary sized needle (about two inches long) is introduced between the two cornua perpendicularly through the membrane. As soon as the needle is felt to have passed the membrane in the sacral canal the butt end of the needle is pushed downwards towards the perineum and the pointed end is pushed up into the sacral canal to a distance one and half to two inches. The needle should not be pushed in too high lest it should puncture the dural sac. The curvature of the sacral canal is such that the needle is more likely to impinge on the posterior wall of the sacrum than puncture the dural sac, and Hertiler has never found it possible to aspirate the dural sac through the sacral canal in spite of repeated attempts. The danger of puncturing the dural sac is thus very little.

Care must be taken to avoid puncturing the veins of the sacral canal. If any blood is noticed coming out of the needle as when a vein is punctured, the position of the needle is slightly changed. The syringe containing the solution is then attached to the needle and the injection is made. An alternative method of avoiding injury to the blood vessels is to start the injection of fluid as soon as the needle passes the membrane and continue the injection slowly as the needle is gradually passed upwards. In this manner the veins are pushed away from the point of the needle by the stream of excaping fluid.

*Extent and duration of anaesthesia.*—Anaesthesia becomes complete in about twenty minutes. It is at first noted at the tip of the coccyx, then extends over the perineum and latterally over the gluteal region. The region of the glans penis or the clitoris is the last to become anaesthetised. The extent of the anaesthesia will be understood from the nerve roots involved, namely the third sacral and all the nerve roots below it, the second sacral also occasionally being affected. The nerves anaesthetised, therefore, are the pudic nerve and its three branches, the haemorrhoidal, the perineal and the dorsalis penis nerves, the visceral branches (sensory nerves) to the pelvic viscera, the muscular branches supplying the levator ani, coccygeus and the sphincter ani externus muscles and the anococcygeal nerve which supplies the area round the tip of the coccyx. Sacral anaesthesia is mainly used for rectal operations. The paralysis of the external sphincter and the levator ani muscle caused by this anaesthesia give such extreme relaxation and such good view of the parts that it can be said to be the ideal anaesthetic for operations in this region. Rectal operations as for piles, fistula in ano, fissures of the anus and abscesses in and about the anus have been performed easily under caudal block.

The method could be utilised for circumcision operations, and for analgesia during dilatation of strictures of the urethra and cystoscopy. It is also alleged to cause diminution of pains during labour though the inten-

sity of uterine contractions is not influenced. Labat recommends the use of caudal block in scatica, coccyalgia and other painful conditions in that region.

The anaesthesia lasts from 45 minutes to two hours. It usually subsides in the inverse order of its onset, the glans and clitoris regaining sensation first and the anococcygeal region last. The advantage of this method of analgesia are very many. As mentioned above, it is the ideal anaesthetic for all rectal operations. In these operations it has the decided advantage of relaxing the anal sphincter to such an extent as to render the dialatation easy and complete without damage to the muscular structures. With inhalation narcosis, relaxation of the sphincter ani is very seldom complete and the forcible manual dilatation necessitated thereby results in local injury and the extreme pain to the patient for several days after the operation, unless the service of a skilled anaesthetist and the employment of a high degree of anaesthesia are resorted to. Again in long standing cases of piles where the patient is suffering from severe anaemia and where general anaesthesia is contra-indicated, this method could be tried without any risk. Sacral anaesthesia is preferable to spinal anaesthesia as the latter requires a special posture during operation, a specially made solution is followed by occasional meningitis or late paralysis and is usually accompanied by a definite fall in blood pressure making it uusafe in patients with a low pressure. As such for rectal operations spinal anaesthesia which has been described by H. Groves as rather more dangerous than the most dangerous general anaesthetic is to be entirely rejected in favour of sacral anaesthesia. Parasacral anaesthesia although it has not the objections of spinal and general anaesthesia has been considered a serious rival to sacral block, but it requires constant practice and long experience to know the various anatomical land-marks of the various foramina for making the punctures and when the injections are made deeply, the danger of puncturing one of the hollow organs of the pelvis cavity is present.

The great point about the sacral anaesthesia is that only a single puncture is made. No special needle or special solution need be used. There is no danger either during the injection or other sequalæ. After injeotion is made, during the waiting period the patient is allowed to sit down comfortably on a bench or chair until he is ready, and for the operation itself any position could be utilised. Retention of urine has never followed its use.

Failures in sacral anaesthesia, apart from the gross errors such as the needle being outside the sacral canal in which case oedema is produced on the post-aspect of the sacrumerior are easily avoided after a little practice and are generally due to too small an amount of fluid being used. It is better and more reliable to use two ounces of a one per cent solution than one ounce of a two per cent solution.

As regards pain during the injection, the usual tendency is to use a needle with a large bore when severe pain may be produced. There is no necessity for the use of any such needle and if an ordinary sized needle about two inches long is employed as mentioned above, the procedure will be about as painless as an intravenous injection.

Rarely, rapid pulse and palpitation of the heart occur during the injection but last only two or three minutes clearing up without the necessity for any actual treatment. The injection is stopped for a while when this occurs and resumed very slowly.

Infections of the region prohibit the use of caudal block because of danger of infecting the sacral canal.

*High sacral anaesthesia.*—By making the injection in the knee chest or in the Trendelenburg position and by increasing the amount of anaesthetic solution used, Schlimpert and Schneider have tried to extend the usefulness of sacral anaesthesia, the legs, the pelvis, the abdomen up to the umbilicus and the lumbar regions become anaesthetised. They recommend 60 c.c. of a 1½ per cent solution of novocaine the anaesthesia extending up to the eighth dorsal segment and taking about two to twenty minutes to become complete. Unfortunately, the after effects such as pallor, dizziness, numbness, perspiration and vomiting are frequently observed and this type of anaesthesia is as dangerous as spinal anaesthesia. These toxic effects might be due to rather the large dose of novocaine used and not to the method of anaesthesia. Braun condemns high sacral anaesthesia and says, rather emphatically, that this anaesthesia is to be entirely rejected, limiting it only to blocking of the pudendal plexus.

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## REVIEW.

### New Drugs and Appliances.

**Interstizial** is a complete extract of the testicular gland. The difficulty in obtaining uniform results with testicular extracts has been due to the difficulty in completely extracting the lipoid active substances contained in the interstitial portion. In *Interstizial* the specific hormones contained in the interstitial part of the gland have been, by special means, extracted. The manufacturers claim that in this product the combination of the hormones contained in the interstitial and germinal parts of the testicle makes it different from the ordinary testicular extracts and that, as such, better and more uniform results may be obtained.

## WARNING.

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**Since unduly severe reactions have been reported after their use, the medical profession is warned not to use NEOARSPHENAMINE (Syn. Novarsenobenzol, Neosalvarsan, Novarsenobillon), Batches No. P. V. 225 to 225-E and SULPHOSTAB (Syn. Sulpharsenamine), Batches 353-A to 353-E, which are over two years in age.**

***Drugs Committee, S. I. M. U.***